Supreme Court, U.S.
FILED
NOV 27 2000
CLERK

(6)

No. 00-665

In The

Supreme Court of the United States

JOSE MONTEMAYOR, COMMISSIONER OF THE TEXAS DEPARTMENT OF INSURANCE; JOHN CORNYN, ATTORNEY GENERAL OF TEXAS,

Petitioners,

v.

CORPORATE HEALTH INSURANCE, INC.; AETNA HEALTH PLANS OF TEXAS, INC.; AETNA HEALTH PLANS OF NORTH TEXAS, INC.; AETNA LIFE INSURANCE COMPANY,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE AMERICAN MEDICAL ASSOCIATION AND THE TEXAS MEDICAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

DONALD P. WILCOX
TEXAS MEDICAL ASSOCIATION
401 W. 15th Street
Austin, TX 78701
Telephone: (512) 370-1335
Fax: (512) 370-1636

RHONDA RHODES
LEONARD NELSON
*CAROLYN QUINN
AMERICAN MEDICAL ASSOCIATION
515 N. State Street
Chicago, IL 60610
Telephone: (312) 464-5059
Fax: (312) 464-5846

Attorneys for Amici Curiae
*(*Counsel of Record)*

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

28 pp

MOTION OF AMERICAN MEDICAL ASSOCIATION AND TEXAS MEDICAL ASSOCIATION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

Pursuant to Sup. Ct. Rule 37.2(b), *Amici Curiae* the American Medical Association ("AMA") and the Texas Medical Association ("TMA") move this Court for leave to file the accompanying brief.

As two of the nation's largest associations of physicians, the AMA and the TMA can offer this Court a unique perspective on the public health issues implicated by the instant appeal, including an analysis of applicable health policy issues. The AMA and the TMA further seek to inform this Court of the associations' internal policies and opinions relevant to this case. The AMA and the TMA believe that the United States Court of Appeals for the Fifth Circuit errantly disposed of issues critical to this appeal, and *amici* wish to address public health concerns that are relevant to the proper resolution of those issues.

The AMA/TMA have been unable to secure the consent of Respondents to the filing of their brief.

Respectfully submitted,

DONALD P. WILCOX
TEXAS MEDICAL ASSOCIATION
401 W. 15th Street
Austin, TX 78701
Telephone: (512) 370-1335

RHONDA RHODES
LEONARD NELSON
*CAROLYN QUINN
AMERICAN MEDICAL ASSOCIATION
515 N. State Street
Chicago, IL 60610
Telephone: (312) 464-5059

Attorneys for Amici Curiae
*(*Counsel of Record)*

TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

STATEMENT OF INTEREST 1

SUMMARY OF ARGUMENT 3

ARGUMENT 6

I. The Texas Legislation Satisfies A Pressing Need In Our Health Care System And Should Not Be Preempted By ERISA 6

II. The Fifth Circuit Neglected To Follow *Travelers, Pegram* And Other Supreme Authority On Eligibility Decisions That Require Determination Of Medical Necessity Or Appropriateness 11

III. Review By This Court Is Necessary To Resolve Conflicts In ERISA Caselaw And To Bring Predictability To Efforts To Secure Safeguards For Adequate Health Care 14

CONCLUSION 19

TABLE OF AUTHORITIES

Page

CASES

California Div. of Labor Standards Enforcement v. Dillingham Constr., 519 U.S. 316 (1997) 12

Corporate Health Ins., Inc. v. Texas Dept. of Ins., 215 F.3d 526 (5th Cir. 2000) ..... *passim*

Corporate Health Ins., Inc. v. Texas Dept. of Ins., 220 F. 3d 614 (5th Cir. 2000) 2

DeBuono v. NYSA-ILA Med. & Clinical Serv. Fund, 520 U.S. 806 (1997) 12

Moran v. Rush Prudential HMO, Inc., No. 99-2574 2000 U.S. App. Lexis 26053 (7th Cir. Oct. 19, 2000) ..... *passim*

New York Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995) ..11, 12

Pegram v. Herdrich, ___ U.S. ___, 120 S. Ct. 2143 (2000) ..... *passim*

Pilot Life v. Dedeaux, 481 U.S. 41 (1987)....5, 15, 16, 17, 18

UNUM Life Ins. Co. of Am. v. Ward, 526 U.S. 358 (1999) 5, 6, 15, 16, 17, 18

FEDERAL STATUTES

Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* (1999) 2, 3, 7

Section 502(a), 29 U.S.C. § 1132(a) ..... *passim*

Section 514(a), 29 U.S.C. § 1144(a) 14, 19

TABLE OF AUTHORITIES – Continued

Page

TEXAS STATUTES

Act of May 22, 1997, 75th Leg., R.S., ch. 163, § 1, 1997 Tex. Gen. Laws 317 ..... 2, 3

TEX. INS. CODE art. 20A.12A 3

TEX. INS. CODE art. 21.58A, § 2(3) 3

OTHER STATES STATUTES AND AUTHORITIES

2000 Alaska Sess. Laws 99 5

ARIZ. REV. STAT. ANN. § 20-2537 (West Supp. 1999) 5

CAL. [INS.] CODE § 10169 (West Supp. 2000) 5

COLO. REV. STAT. § 10-16-113.5 (West 1999) 5

CONN. GEN. STAT. § 38a-478n (West Supp. 2000) 5

DEL. CODE ANN. tit. 16, § 9119 (2000) 5

D.C. CODE § 32-571.7 (Lexis Supp. 2000) 5

2000 Fla. Laws ch. 00-256 (West) 5

GA. CODE ANN. § 33-20A-32 (2000) 5

2000 Haw. Sess. Laws 250 5

215 ILCS 125/4-10 (West Supp. 2000) 5

IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000) 5

IOWA CODE ANN. § 514J (West 2000) 5

KAN. STAT. ANN. § 40-22a13 (Supp. 1999) 5

2000 Kentucky Laws Reg. Sess. 262 (West) 5

TABLE OF AUTHORITIES – Continued

Page

La. Rev. Stat. Ann. § 22:3081 (2000) 5

2000 Me. Legis. Serv. 742 (West) 5

Md. Code Ann. [Ins.] §§ 15-10A through 15-10B (Lexis Supp. 1999) 5

2000 Mich. Legis. Serv. 251 (West) 5

Minn. Stat. Ann. § 62Q.73 (West Supp. 2000) 5

Mo. Rev. Stat. § 376.1385 (1997) 5

Mont. Code Ann. § 33-37-102 (1999) 5

N.H. Rev. Stat. Ann. 420-J:5 (2000) 5

N.J. Stat. Ann. §§ 26:2S-11, 26:2S-12 (West Supp. 2000) 5

N.M. Adm. Code tit. 13, § 10.17.24 (Michie Supp. 2000) 5

N.Y. [Ins.] Law § 4904 (McKinney 1999) 5

N.C. Gen. Stat. §§ 58-50-61, 58-50-62 (1998) 5

Ohio Rev. Code Ann. § 1751.84 (Baldwin Supp. 2000) 5

Okla. Stat. Ann. tit. 63, § 2528.3 (West 1999) 5

40 Pa. Cons. Stat. § 991.2162 (1998) 5

R.I. Gen. Laws § 23-17.12-10 (Lexis Supp. 2000) 5

2000 S.C. Acts 380 5

Tenn. Code Ann. § 56-32-227 (West 1999) 5

Utah Code Ann. § 31A-22-629 (2000) 5

TABLE OF AUTHORITIES – Continued

Page

VT. STAT. ANN. tit. 8, § 4089f (1998) 5

VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000) 5

2000 Wash. Legis. Serv. 5 (West) 5

2000 Wisc. Legis. Serv. 155 (West) 5

OTHER AUTHORITIES

American Medical Association, *Policy Compendium* H-165.875 at 308 (1999) 6

American Medical Association, *Policy Compendium* H-165.883 at 310 (1999) 7

American Medical Association, *Policy Compendium* H-165.892 at 312 (1999) 6

American Medical Association, *Policy Compendium* H-165.895 at 312 (1999) 6

Richard F. Corlin, MD, Statement of the American Medical Association to the Committee on Health, Education, Labor and Pensions, United States Senate (March 2, 1999) 8

Timothy T. Flaherty, MD, Statement of the American Medical Association to the Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, United States House of Representatives (April 20, 1999) 8

The Lewin Group, Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals (November 18, 1997) 9

TABLE OF AUTHORITIES – Continued

Page

Managed Care Liability Update, 6 Health Plan and Provider Report (BNA) No. 32, at 979-91 (Aug. 9, 2000) 13

Rowland H. Long, *The Law of Liability Insurance* (1984) 7

Robert J. Mehr & Emerson Cammack, *The Principles of Insurance* (6th ed. 1976) 7

Karen Pollitz, Geraldine Dallek, Nicole Tapay, External Review of Health Plan Decisions: An Overview of Key Program Features in States and Medicare (The Kaiser Family Foundation, November 1998) 9

United States General Accounting Office, Employer-Based Managed Care Plans: ERISA's Effect on Remedies For Benefit Denials and Medical Malpractice (July 1998) 7

STATEMENT OF INTEREST

Amicus the American Medical Association ("AMA"), an Illinois not for profit corporation, is an association of approximately 300,000 physicians who practice throughout the United States. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these still remain its core purposes. Its members practice in all fields of medical specialization, and it is the largest medical society in the United States.[1]

Amicus Texas Medical Association ("TMA"), a Texas not for profit corporation, is an association of physicians who practice in the State of Texas. TMA was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its maxim continues in the same direction: "Physicians Caring for Texans." Its approximately 36,000 members, representing more than 83% of all licensed physicians in Texas, practice in all fields of medical specialization. As an association of physicians and medical students, TMA is interested in and concerned with matters before this Court which affect the health of the citizens of Texas.[2]

---

[1] Counsel for the AMA authored this brief in its entirety. No monetary contributions to the preparation or submission of this brief were received from any source other than the AMA/State Medical Society Litigation Center. Sup. Ct. R. 37.6.

[2] *Amici* file this brief as members of the American Medical Association/State Medical Society Litigation Center ("Litigation Center"). The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

The membership of the AMA and the TMA are devoted to securing the best possible medical care for their patients. They promote a health care environment in which adequate medical care is available for all, regardless of the ability or inability to pay for that care. The holding of the United States Court of Appeals in *Corporate Health Insurance, Inc. v. Texas Dept. of Insurance*, 215 F.3d 526 (5th Cir. 2000), *rehearing denied*, 220 F.3d 641 (2000), impacts the accessibility of satisfactory medical care, thereby raising issues of significant interest to the AMA and the TMA.

In the considered opinion of the AMA and the TMA, the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001, *et seq.* (1999)) ("ERISA"), is frequently applied so as to impede uniform access to adequate medical care. Rather than limiting ERISA to the administrative purposes for which it was intended, some courts, including the Fifth Circuit Court of Appeals in this case, extend ERISA's reach beyond the scope intended by its drafters, and declare that ERISA preempts laws more properly reserved to a state's sovereign power. By finding that ERISA preempts an independent, external review of a denial of medical benefits, the Fifth Circuit frustrated Texas' legitimate attempt to regulate medical care rendered to its citizens. The Texas Health Care Liability Act (Act of May 22, 1997, 75th Leg., R.S., ch. 163, § 1, 1997 Tex. Gen. Laws 317) ("THCLA") is an enlightened legislative effort to ameliorate the potentially devastating consequences of an improper denial of medical insurance benefits. THCLA is an important adjunct to the services that *amici's* members provide to their patients and, consequently, furthers the interests of public health.

For these reasons, *amici* support the Petition for *certiori* filed by Petitioners Jose Montemayor, Commissioner of the Texas Department of Insurance and John Cornyn, Attorney General of Texas ("Petitioners"). *Amici* endorse the arguments made in Petitioners' brief. *Amici* urge the Court to grant a writ of *certiorari* so that the Court may resolve the important issues raised by this appeal.

SUMMARY OF ARGUMENT

Members of the AMA and the TMA dedicate themselves to promoting the best interests of their patients, including the patients' interests as recipients of health care benefits. *Amici's* members view with alarm the increasing tendency of health care insurers to place their pecuniary well-being ahead of adequate medical care for health plan beneficiaries. One of the inequities routinely faced by health care consumers is a system of benefit determination which is controlled solely by insurers and which offers no meaningful method for beneficiaries to appeal a denial of benefits. Therefore, *amici* encourage legislation allowing patients access to an independent, external review system to contest denials of health care benefits.

The Fifth Circuit's decision in *Corporate Health Insurance, Inc. v. Texas Dept. of Insurance*, 215 F.3d 526 (5th Cir. 2000), *rehearing denied*, 220 F.3d 641(2000), undermines a legislative attempt to rectify an imbalance in our health care delivery system. In *Corporate Health*, the Fifth Circuit reviewed a challenge by private health care insurers to the Texas Health Care Liability Act (Act of May 22, 1997, 75th Leg., R.S., ch. 163, § 1, 1997 Tex. Gen. Laws 317)), which amended the Texas Insurance Code to create an Independent Review Organization (TEX. INS. CODE arts. 20A.12A, 21.58A, § 2(3)) ("IRO"). The IRO provisions establish a mechanism by which patients can appeal an "adverse determination", defined as:

> "[A] determination by [an HMO] or utilization review agent that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are not appropriate." TEX. INS. CODE art. 20A.12(c)(1).

The insurers alleged, *inter alia*, that certain portions of the law were preempted by the Employee Retirement Income Security Act 29 U.S.C. § 1001, *et seq.* (1999) ("ERISA"). The Fifth Circuit ruled that pertinent portions

of the IRO were preempted, because the review provisions "conflict with [Section 502(a),] a substantive [remedial] provision of ERISA." *Id.* at 539.

The *Corporate Health* opinion ignores the common sense arguments and objective data illustrating the need for an independent grievance review process. By finding the IRO preempted by ERISA, moreover, the Fifth Circuit extended the statute's preemptive reach well beyond the boundaries intended by the drafters of ERISA. This Court has made clear that ERISA regulates the administration of health and welfare benefit plans but was never intended to stifle a state's right to regulate, through statute or common law, substantive areas of law reserved to the state, such as standards governing the quality of medical care dispensed within the state. Nonetheless, the Fifth Circuit strayed beyond the intended parameters of ERISA preemption, and held that the federal statute preempted the state's right to regulate the quality of medical care rendered within Texas. This Court's intervention is needed to correct this error.

Amici also urge the Court to grant *certiorari* to resolve a conflict among the federal circuit courts, namely, whether independent review provisions like the one construed by the Fifth Circuit conflict with the remedies set forth in ERISA and, therefore, are preempted by ERISA. In *Corporate Health*, the Fifth Circuit held that a conflict existed, and found the IRO preempted. In *Moran v. Rush HMO*, 2000 U.S. App. Lexis 26053 (7th Cir. October 19, 2000), the Seventh Circuit Court of Appeals recently construed a virtually identical scheme enacted by the Illinois legislature and found no ERISA preemption. Should this Court fail to grant *certiorari*, the disparity between the decisions of the Fifth and Seventh Circuits will make enforcement of similar independent review provisions adopted by 33 other states and the District of Columbia

capricious, rather than uniform.[3] The lower courts and state legislatures look to the Court to resolve this dilemma.

Additionally, the *Corporate Health* decision highlights issues yet unresolved within this Court's own opinions. In *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987) (*"Pilot Life"*), the Court held that a state law that conflicts with the exclusive remedies prescribed by Section 502(a) of ERISA (29 U.S.C. § 1132(a)) must yield to ERISA preemption. In *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (*"Ward"*), however, the Court indicated that a state law "saved" from ERISA preemption because it regulates insurance will, by virtue of ERISA's savings clause, not be preempted regardless of any conflicts with the remedial provisions of ERISA. Nonetheless, the issue of whether the

---

[3] 2000 Alaska Sess. Laws 99, ARIZ. REV. STAT. ANN. § 20-2537 (West Supp. 1999), CAL. [INS.] CODE § 10169 (West Supp. 2000), COLO. REV. STAT. § 10-16-113.5 (West 1999), CONN. GEN. STAT. § 38a-478n (West Supp. 2000), DEL. CODE ANN. tit. 16, § 9119 (2000), D.C. CODE § 32-571.7 (Lexis Supp. 2000), 2000 Fla. Laws ch. 00-256 (West), GA. CODE ANN. § 33-20A-32 (2000), 2000 Haw. Sess. Laws 250, 215 ILCS 125/4-10 (West Supp. 2000), IND. INS. CODE ANN. § 27-13-10.1-1 (West 2000), IOWA CODE ANN. § 514J (West 2000), KAN. STAT. ANN. § 40-22a13 (Supp. 1999), 2000 Kentucky Laws Reg. Sess. 262 (West), LA. REV. STAT. ANN. § 22:3081 (2000), 2000 Me. Legis. Serv. 742 (West), MD. CODE ANN. [INS.] §§ 15-10A through 15-10B (Lexis Supp. 1999), 2000 Mich. Legis. Serv. 251 (West), MINN. STAT. ANN. § 62Q.73 (West Supp. 2000), MO. REV. STAT. § 376.1385 (1997), MONT. CODE ANN. § 33-37-102 (1999), N.H. REV. STAT. ANN. 420-J:5 (2000), N.J. STAT. ANN. §§ 26:2S-11, 26:2S-12 (West Supp. 2000), N.M. ADM. CODE tit. 13, § 10.17.24 (Michie Supp. 2000), N.Y. [INS.] LAW § 4904 (McKinney 1999), N.C. GEN. STAT. §§ 58-50-61, 58-50-62 (1998), OHIO REV. CODE ANN. § 1751.84 (Baldwin Supp. 2000), OKLA. STAT. ANN. tit. 63, § 2528.3 (West 1999), 40 PA. CONS. STAT. § 991.2162 (1998), R.I. GEN. LAWS § 23-17.12-10 (Lexis Supp. 2000), 2000 S.C. Acts 380, TENN. CODE ANN. § 56-32-227 (West 1999), UTAH CODE ANN. § 31A-22-629 (2000), VT. STAT. ANN. tit. 8, § 4089f (1998), VA. CODE § 38.2-5900 to 38.2-5905 (Michie Supp. 2000), 2000 Wash. Legis. Serv. 5 (West), 2000 Wisc. Legis. Serv. 155 (West).

savings clause in ERISA "trumps" the remedial provisions of Section 502(a) of ERISA was not squarely addressed in *Ward*. *Corporate Health* now brings that issue before this Court, making resolution of the issue appropriate.

ARGUMENT

I. The Texas Legislation Satisfies A Pressing Need In Our Health Care System That Should Not Be Preempted By ERISA

For the last several years, *amici* have advocated the need for external, independent review of denials of health care benefits. The AMA endorses legislation "to provide that ERISA does not preempt a state's jurisdiction over the quality of medical services delivered when the state regulates managed care organizations making medical necessity decisions for covered medical services." American Medical Association, *Policy Compendium* H-165.875 at 308 (1999) ("*Policy Compendium*").[4] The AMA seeks to strengthen the health care system for patients and physicians by promoting policies that make patients and the physician/patient relationship superior to any other concern. *Policy Compendium*, H-165.895 at 312. To this end, the AMA will target, among other things, "insurance reform." *Id.* In its policy H-165.892, the AMA "encourages and supports federal legislation . . . including the necessary ERISA . . . waivers, to allow states to pursue health system reform at the state level." *Policy Compendium*, H-165.892 at 312. In 1996, the AMA pledged that it would, through amendment to ERISA and through enactment of state and federal legislation, seek regulation of self-insured insurance plans to ensure that they were

---

[4] H-165.875 refers to policy 165.875, as adopted by the AMA House of Delegates, the AMA's principal policy-making body. AMA policies can be found at www.ama-assn.org/apps/pf-online.

regulated "in regard . . . to appeals and grievance procedures." *Policy Compendium,* H-165.883 at 310.

Several considerations drive *amici's* interest in accountability by health care insurers. The interpretation and application of ERISA affects hundreds of millions of people. As noted by the General Accounting Office in 1998, "[m]ost workers and their families in the private sector receive their health insurance coverage through employers . . . [A]bout 125 million people receive health insurance through about 2.5 million employer-based health care plans covered by ERISA." United States General Accounting Office, Employer-Based Managed Care Plans: ERISA's Effect on Remedies for Benefit Denials and Medical Malpractice at 6 (July 1998) ("GAO"). Thus, this Court's resolution of the interplay between ERISA preemption and independent benefit review will have far-reaching consequences.

Further, although ERISA-controlled health plans are, by definition, sponsored by employers, they are not an entirely free benefit of employment. Employees pay a premium to obtain health care insurance from the plan. In turn, the health plan is bound to provide health care as promised by the plan as a self-insured entity, or by a third-party insurer with whom the employer has contracted. *Id.* at 5; 29 U.S.C. § 1022 (1999). Patients are therefore entitled to receive the benefits for which they have paid. Additionally, if a request for coverage is denied by an insurance company that drafted the terms of the contract, and the beneficiary is allowed no right of recourse, general insurance principles suggest that any ambiguities concerning the breadth of medical coverage available to the plan participant shall be construed against the insurer. See Long, *The Law of Liability Insurance* 16-39 (1984); Mehr & Cammack, *The Principles of Insurance* 162 (6th ed. 1976).

When, as in this case, benefits can be denied as being "medically unnecessary", the presumption of unfairness to the health care consumer is even stronger. A benefit determination grounded in medical necessity suggests

that only a licensed physician is qualified to grant or deny benefits. Timothy T. Flaherty, MD, Statement of the American Medical Association to the Subcommittee on Employer-Employee Relations, Committee on Education and the Workforce, U.S. House of Representatives at 3 (April 20, 1999) ("Flaherty Statement"). Regardless, some insurers employ non-physicians to make benefit decisions grounded in medical necessity. *Id.* at 3. Combined with the fact that benefit decisions are often motivated by the insurer's pecuniary interest, and not the beneficiary's medical interest (Richard F. Corlin, MD, Statement of the American Medical Association to the Committee on Health, Education, Labor and Pensions, United States Senate (March 2, 1999)), the denial of benefits becomes immediately suspect. The only way to guarantee that the insurer fulfils its contractual obligation to provide medically necessary care to plan participants is to subject contested decisions to an external reviewer, qualified in the medical specialty at issue, and with no financial ties to the insurer. Before the United States House of Representatives Sub-Committee of Employer-Employee Relations, Timothy Flaherty, MD, Secretary-Treasurer of the AMA Board of Trustees testified:

> "The absence of independent review enables plans to make unfair and arbitrary decisions with virtually no consequences. Patients who are denied access to necessary care are then forced to pay out-of-pocket for necessary medical service, which may in fact be covered services. More important, patients who are forced to forego necessary care awaiting the real outcome of a coverage or medical necessity dispute may suffer real, sometimes irreversible harm." *Id.* at 2.

Additionally, the enactment of ERISA predated the shift in this country from predominantly fee-for-service medical care to the managed care environment that dominates the medical landscape today. GAO at 1. Pursuant to traditional fee for service care, patients were provided

direct access to their physicians and payment issues were addressed after treatment. Today, however, health plans generally require that coverage decisions must be decided before medical service will be provided. "Thus, under today's health plan structure, a denial of a claims equates to a denial of benefits, especially for those who cannot afford to pay out of their pockets." Flaherty Statement at 4.

Amici are aware of this Court's recent announcement that it has no intention of dismantling managed care as it currently exists. *Pegram v. Herdrich*, ___U.S.___, 120 S. Ct. 2143, 2150-51 (2000). Neither AMA nor TMA advocate such a dramatic result in this case. However, the associations urge the Court to consider the benefits to consumers and to the health care industry that will result should the Court grant *certiorari* in this case, and on the merits, interpret ERISA as *amici* contend it was intended to be interpreted. In a 1997 study, the Lewin Group found that the existence of fair and impartial decision-makers gave consumers greater confidence in their health care plans and coverage. The Lewin Group, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals* at 31 (November 18, 1997). By increasing an insurer's accountability through an independent reviewer, moreover, consumers have more leverage in dealing with the insurer. *Id.* at 32. The study also predicted that the existence of effective external review procedures would reduce the number of challenges to benefit denials in the courts, and would motivate health plans to consider benefit determinations with greater care, in order to avoid the external appeal process. *Id* at 31.

A 1998 study by The Kaiser Family Foundation compared the external review programs available through Medicare and in thirteen states. Karen Pollitz, Geraldine Dallek, Nicole Tapay, *External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare* (The Kaiser Family Foundation, November 1998). While the programs were different in several ways,

the researchers also found "striking similarities in many respects." *Id.* at 5. The study found, for example, parity between the number of plan decisions affirmed and reversed by independent reviewers: "Across all programs studied, external review overturned health plan decisions between one third and two thirds of the time." *Id.* These results increased the trust of the regulated companies that they would receive a fair hearing before the reviewer. *Id.* at 6. Moreover, the costs of external review were relatively low, particularly when compared to the costs of standard litigation. In all but one of the states studied, the cost of external review was $500 or less. *Id.* Medicare cases subject to external review cost $300. *Id.*

Independent review procedures were also regarded as having a "sentinel" effect on health plan behavior. *Id.* at 6. In other words, health plans learned from the external review processes, and came to understand what decisions independent reviewers were likely to reverse, and which ones would not be reversed. As a consequence, requests for review of denial of a particular form of care tended to decline with time, as the plan came to understand the state's expectations. *Id.* Critically, too, the study found even that health care insurers had high regard for the external review processes:

> "Regulators, external review agency staff, and industry representatives alike reached this conclusion about the process. The fact that the disposition of external review equally favored consumers and plans was cited as both an indication of the need for the process as well as evidence of its objectivity and creativity. . . . Several experts also noted that the growing number of private health plans voluntarily submitting to external review could be interpreted as a vote of confidence in the external review process. Health plan industry representatives suggested that the external review process

helped improve public perceptions about managed care and reduced the need for health plan liability laws." *Id.* at 6-7.

The fact that health care insurers realize benefits from external review processes only increases the urgency of the need for this Court to grant *certiorari* in this appeal. Independent review of health care benefit denials are needed to safeguard the public health and to buttress public confidence in the managed care system. If permitted to stand, the precedent set by the *Corporate Health* opinion will harm health care consumers and impede positive aspects of the managed care system that this Court believes should be perpetuated.

II. The Fifth Circuit Neglected To Follow *Travelers*, *Pegram* And Other Supreme Court Authorities On Eligibility Decisions That Require Determinations Of Medical Necessity Or Appropriateness

Amici's conclusion that independent review procedures can directly impact public health highlights a core misapprehension of the Fifth Circuit's holding in *Corporate Health*. In ruling that the remedial provisions of ERISA's Section 502(a) preempted the IRO law, the Court errantly extended the preemptive authority of ERISA and improperly impinged upon Texas' sovereign right to dictate standards of medical care for its citizenry. Specifically, the Fifth Circuit ignored Supreme Court cases stating that ERISA does not, and is not intended to, preempt a state exercise of power in substantive areas traditionally reserved to state sovereignty.

In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645, 115 S. Ct. 1671, 131 L.Ed. 2d 695 (1995) (*Travelers*), this Court construed state legislated surcharges levied against hospital patients insured by commercially owned insurance companies. The plaintiff insurance companies sued officials of the State of New York, alleging that the state scheme

"related to" employee benefit plans subject to ERISA, and as a consequence, was preempted by ERISA.

The Court found the plaintiffs' argument meritless. *Travelers*, 514 U.S. at 661. The Court ruled that the "relation" suggested by the plaintiffs was too tenuous to withstand scrutiny. Moreover, the Court stated that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern." *Id.* at 661; see also *California Division of Labor Standards Enforcement v. Dillingham Construction N.A. Inc.*, 519 U.S. 316 (1997); *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).

In *Pegram v. Herdrich*, 120 S. Ct. 2143 (2000), the Court again addressed the interaction of a state's authority to regulate medical care dispensed within its borders, and the breadth of the ERISA statute's reach. In *Pegram*, Herdrich received treatment from Dr. Pegram, a physician owner of the Carle Clinic, an HMO. Herdrich alleged that Pegram delayed necessary medical treatment for Herdrich. From these facts, Herdrich attempted to plead a breach of fiduciary duty under ERISA against Carle.

The Court held that plaintiff failed to plead a breach of fiduciary duty, as stated in ERISA. *Pegram*, 120 S. Ct. at 2155-56. The Court observed that the fiduciary duties encompassed by the ERISA statute include acting as a manager, administrator or financial advisor to a benefits plan. *Pegram*, 120 S. Ct. at 2151. By contrast, the allegations of Pegram's complaint implicated both a determination of eligibility for benefits under the benefits plan, and matters concerning medical treatment.

The Court concluded that mixed treatment/eligibility determinations are not fiduciary in nature. *Id.* at 2155. In each instance where a plaintiff claimed that an HMO physician breached his fiduciary duty in reaching a mixed eligibility/treatment decision, the finder of fact would have to refer to standards of reasonable and customary medical practice. A fiduciary obligation encompassing mixed determinations, therefore, would merely

replicate state malpractice claims. *Id.* at 2158. The Court further recognized that subsuming malpractice standards into ERISA fiduciary responsibilities created a possibility that state malpractice claims could be preempted by ERISA. *Id.* The Court rejected this possibility, stating: "[W]e know that Congress had no such haphazard boons in prospect when it defined the ERISA fiduciary, nor such a risk to the efficiency of federal courts as a new fiduciary-malpractice jurisdiction would pose in welcoming such unheard-of fiduciary litigation." *Id.*

In this case, the Fifth Circuit construed a provision of the Texas insurance code which prescribed independent review for denial of benefits when the denial was grounded in "medical necessity" or "appropriateness". *Corporate Health*, 215 F.3d at 537. Under *Pegram*, "medical necessity" determinations require the exercise of medical judgment and thus, inherently, are determinations that mix benefit eligibility considerations with medical decision making. *Pegram*, 120 S. Ct. at 2155.[5]

Congress did not intend to extend the power of ERISA into the arenas covered by mixed treatment/eligibility decisions. *Id.* at 2156; *see also Managed Care Liability Update*, 6 Health Plan and Provider Report (BNA) No. 32, at 979-91 (Aug. 9, 2000). (Analysis of Federal HMO Act (42 U.S.C. § 300e, *et seq.*), which was enacted the year before Congress passed ERISA, indicates that Congress intended the states to regulate "medical necessity" determinations and that Congress deliberately rejected federal regulation of quality of care, so that those decisions could rest with the states). *Amici* respectfully suggest that the Fifth Circuit erred when it concluded that the review provisions substantively conflicted with the enforcement provisions of ERISA. Therefore, independent review of

---

[5] Indeed, the *Pegram* Court expressly mentioned the "medical necessity requirement that conditions the HMO's obligation to . . . pay for that particular procedure" as a type of eligibility decision that "cannot be untangled from physicians' judgments about reasonable medical treatment." *Id.* at 2154.

benefit decisions involving medical necessity or appropriateness are not preempted by ERISA.

III. Review By This Court Is Necessary To Resolve Conflicts In ERISA Caselaw And To Bring Predictability To Efforts To Secure Safeguards For Adequate Healthcare

Petitioners have thoroughly explained how the Circuits conflict in their interpretation and application of the ERISA statute. In light of the excellent arguments articulated by Petitioners, and mindful of this Court's admonition in Supreme Court Rule 37(a), AMA/TMA will not belabor points already made concerning the present confusion in ERISA interpretation. *Amici* do contend, however, that a recent decision of the Seventh Circuit Court of Appeals, directly at odds with the holding of the Fifth Circuit, not only illustrates a material disagreement among federal appellate courts, but also reveals an underlying conflict among this Court's ERISA-based decisions. Resolution of this conflict is urgently required so that AMA/TMA and anyone else interested in safeguarding basic medical rights can draft effective legislation, not subject to ERISA preemption.

In *Corporate Health*, the IRO construed by the Fifth Circuit allows patient appeals of "adverse determinations" of medical coverage, meaning, a denial by the benefit provider of health care coverage because the insurer found the requested coverage inappropriate or not medically necessary. *Corporate Health*, 215 F. 3d at 537. The Fifth Circuit first determined that the law was not preempted under Section 514 of ERISA. Whether the law "related to" ERISA pursuant to Section 514 was not determinative; as a state law regulating insurance, it was exempt from preemption under Section 514's "savings clause". *Id.* at 538. However, the Fifth Circuit ruled next that the IRO conflicted with, and thus was preempted by, the terms of Section 502(a) of ERISA. *Id.* at 539. Section 502(a) enumerates the remedies available for violation of

the statute. Relying primarily on *Pilot Life Ins. v. Dedeaux*, 481 U.S. 41 (1987) (*"Pilot Life"*), the Fifth Circuit viewed the independent review procedures of the Texas statute as an "alternative mechanism through which plan members may seek benefits due them under the terms of the plan – the identical relief offered under [Section 502(a)] of ERISA. As such, the independent review provisions conflict with ERISA's exclusive remedy and cannot be saved by the savings clause." *Id.*

Interpreting a section of the Illinois HMO Act virtually identical to the Texas IRO law, the Seventh Circuit Court of Appeals reached the opposite conclusion. In *Moran v. Rush HMO*, 2000 U.S. App. LEXIS 26053 (2000), a majority of a divided Seventh Circuit court held that ERISA did not preempt Section 4-10 of the HMO Act, the authority pursuant to which *Moran* asserted her claim. Like the Fifth Circuit in *Corporate Health*, the Seventh Circuit found the independent review law satisfied the savings clause test, and therefore escaped preemption as a law that relates to plan administration. *Id.* at *8-9. Unlike the IRO in *Corporate Health*, however, the Seventh Circuit found no conflict between the review provisions of Section 4-10 and the ERISA remedies set forth in Section 502(a). *Id.* at *10.[6]

Instead, the court relied on this Court's decision in *UNUM Life Ins. Co. v. Ward*, 526 U.S. 358 (1999) (*"Ward"*), and stated that statutory insurance provisions like Section 4-10 are incorporated into contracts of insurance and become substantive provisions of the contract. *Id.* In *Moran*, the Court continued, the benefit plan is an insurance contract. Because the provisions of Section 4-10 have

---

[6] The disagreement over the proper interpretation of independent review provisions runs not just between the circuits. Four judges of the Seventh Circuit voiced objection to the majority's holding. The dissent stated that "[t]he panel's decision creates a square conflict with another circuit . . . and will affect an enormous number of cases." *Moran v. Rush HMO*, 2000 U.S. App LEXIS at *12 (Posner, J., dissenting).

been incorporated into the plan, a suit by Moran to "enforce [Section 4-10] is simply a suit to enforce the terms of the plan – precisely the sort of suit that is contemplated under Section 502 . . . to 'enforce rights' and 'recover benefits' under the plan." *Id.* The HMO Act did not provide an alternative, conflicting remedy for Moran to recover benefits. It merely established a remedy available pursuant to the plan.

The conflict between *Corporate Health* and *Moran* is plain. Two federal appellate courts interpret nearly identical enactments differently, rendering the law effective for all health care beneficiaries (including those subject to ERISA) in one state, but denying that remedy to any beneficiary of ERISA-sponsored plans in another state. This conflict presents an untenable situation, creating confusion among legislators and courts as they attempt to craft and apply alternatives for insureds denied health care coverage. Any efforts to reconcile the laws and to create workable alternatives, if necessary, are indefinitely stymied until this Court addresses the conflict.

On another level, the discordance between *Moran* and *Corporate Health* reflects an irreconcilable difference between two decisions of this Court that, by virtue of the conflict now existing between the Seventh and Fifth Circuits, compels action by this Court. As stated previously, the Fifth Circuit grounded its holding in *Pilot Life* and, to a lesser degree, *Ward*. The Seventh Circuit based its holding, in relevant part, on *Ward*.

In *Pilot Life*, this Court was asked to decide whether ERISA preempted a state common law action for bad faith breach of contract. Plaintiff alleged that the insurance company from which plaintiff's employer purchased group health insurance never intended to provide the benefits promised to plaintiff. Plaintiff's complaint sought damages for emotional distress and punitive damages. The *Pilot Life* court found that ERISA preempted plaintiff's claim. *Pilot Life*, 481 U.S. at 51, 54. The cause of action was not, as plaintiff asserted, exempt from ERISA preemption by virtue of the ERISA savings clause. *Id.* at

50-51. The bad faith breach of contract action was not a law derived from or solely applicable to insurance contracts. It owed its origins to general contract and tort law developed in Mississippi. For this reason, Plaintiff's claim failed the first consideration of the savings clause test, whether from a "common sense view" the law regulates insurance. *Id.*

The *Pilot Life* court further found that the breach of contract claim conflicted with Section 502(a) of ERISA, which prescribes the civil remedies available under ERISA. *Id.* at 54. Pursuant to Section 502(a), a plan participant or beneficiary may sue for enforcement of rights under a health benefit plan or for recovery of benefits improperly denied, but no more. The scope of the remedy's provision, moreover, was purposefully broad, so that it preempted the exercise of both conflicting and supplementary remedies not otherwise available pursuant to ERISA. *Id.*

Eleven years after *Pilot Life*, this Court decided *Ward*, 526 U.S. 358. There, the Court examined California's "notice prejudice rule", which states that an insurer cannot raise late notice of a claim as a bar to coverage for that claim, unless the insurer can demonstrate that it was harmed by virtue of the untimely notice. This law, the Court held, could be saved from ERISA preemption under ERISA's savings clause. *Id.* at 374. In contrast to the bad faith contract claim at issue in *Pilot Life*, the California law was developed solely for and applied only to insurance contracts. *Id.* at 371. It was not a controlling rule of law for non-insurance contracts. Further, by operation of California law, the notice prejudice rule was automatically incorporated into any California contract of insurance. *Id.* at 374.

The Court also held that the notice prejudice rule was not preempted by the remedial terms of Section 502(a) of ERISA. *Id.* at 376-77. The notice prejudice rule was automatically incorporated into the plaintiff's health plan, the insurance contract at issue in the case. By virtue of the incorporation, it became a term of the plan so that when,

as in *Ward*, a participant sued under Section 502(a) to enforce the terms of the plan, those plan terms included the notice prejudice rule. The Court stated: "Ward sued under Section 502(a)(1)(B) 'to recover benefits due . . . under the terms of this plan.' The notice-prejudice rule supplied the relevant rule of decision for this Section 502(a) suit. The case therefore does not raise the question whether Section 502(a) provides the sole launching ground for an ERISA enforcement action." *Id.*

Critically, the Court addressed in a footnote an issue raised by the United States as an *amicus curiae*. *Id.* at 377, n. 7. The United States noted that in *Pilot Life*, the bad faith law was found to conflict with Section 502 and therefore the remedies sought by the plaintiff were pre-empted by ERISA. By contrast, the United States argued, the notice prejudice rule in *Ward* was a law that regulated insurance and was subject to the savings clause. Because the savings clause indicated an intent by the drafters of ERISA not to preempt laws regulating insurance, the United States asserted then the mere fact that the law provides "a state-law cause of action or remedy" should not subject the law to ERISA preemption under Section 502(a). *Id.*

The *Ward* court held that it need not address the effect of Section 502(a) preemption on a state law that was otherwise "saved" under the savings clause from ERISA preemption. *Id.* The facts before it did not require the Court to reach that issue. Rather, the Court concluded, plaintiff sought relief under Section 502(a) for denial of benefits, a remedy clearly allowed under ERISA, and thus plaintiff was not seeking a remedy that could conflict with or supplant the explicit remedies approved by the drafters of ERISA. *Id.*

In the instant appeal, however, the conflict presaged by the United States in *Ward* has emerged in *Corporate Health* and *Moran* and necessitates this Court's intervention. In both cases, the courts concluded that the state

laws at issue regulated insurance and therefore were "saved" from preemption. The *Moran* court ruled that the law was not preempted under Section 502(a) because, as an insurance law or regulation, it was incorporated into the health plan and subject to enforcement under Section 502(a). *Moran*, 2000 U.S. App. Lexis at *10. *Corporate Health* failed to adopt the same reasoning from the *Ward* court, and in fact cited *Ward* as authority for holding the IRO provision preempted by Section 502(a). *Corporate Health*, 514 F. 3d at 538. Thus, one court, *Moran*, interprets ERISA to allow a law to supplement the remedial provision of Section 502(a) as long as the law otherwise satisfies the necessary elements of the savings clause test. *Corporate Health*, by contrast, does not read the savings clause as superior to the preemption of Section 502(a). The Fifth Circuit reads ERISA to preempt a law that offers remedies other than those enumerated in Section 502(a), even if that law is saved from preemption by operation of the savings clause.

CONCLUSION

The differences between Circuits as to the preemptive effect of ERISA on independent review laws will preclude further implementation of these laws until this Court intervenes and clarifies which Circuit has reached the correct result. By so doing, the Court can also resolve the conflict between its own decisions regarding the proper application of the preemption language in Sections 514 and 502 of ERISA. The issues elucidated above must be addressed so that health care consumers can test seemingly profit-driven, arbitrary denials of health care by insurers against the scrutiny of independent physicians. Meaningful reform of managed care practices affecting

millions of health care consumers rests on this Court's decision to grant or deny *certiorari*.

Respectfully submitted,

DONALD P. WILCOX
TEXAS MEDICAL ASSOCIATION
401 W. 15th Street
Austin, TX 78701

RHONDA RHODES
LEONARD NELSON
*CAROLYN QUINN
AMERICAN MEDICAL ASSOCIATION
515 N. State Street
Chicago, IL 60610

Attorneys for Amici Curiae
*(*Counsel of Record)*